Independent Practitioner

Winter 2024 • Volume 44 Number 1
division42.org

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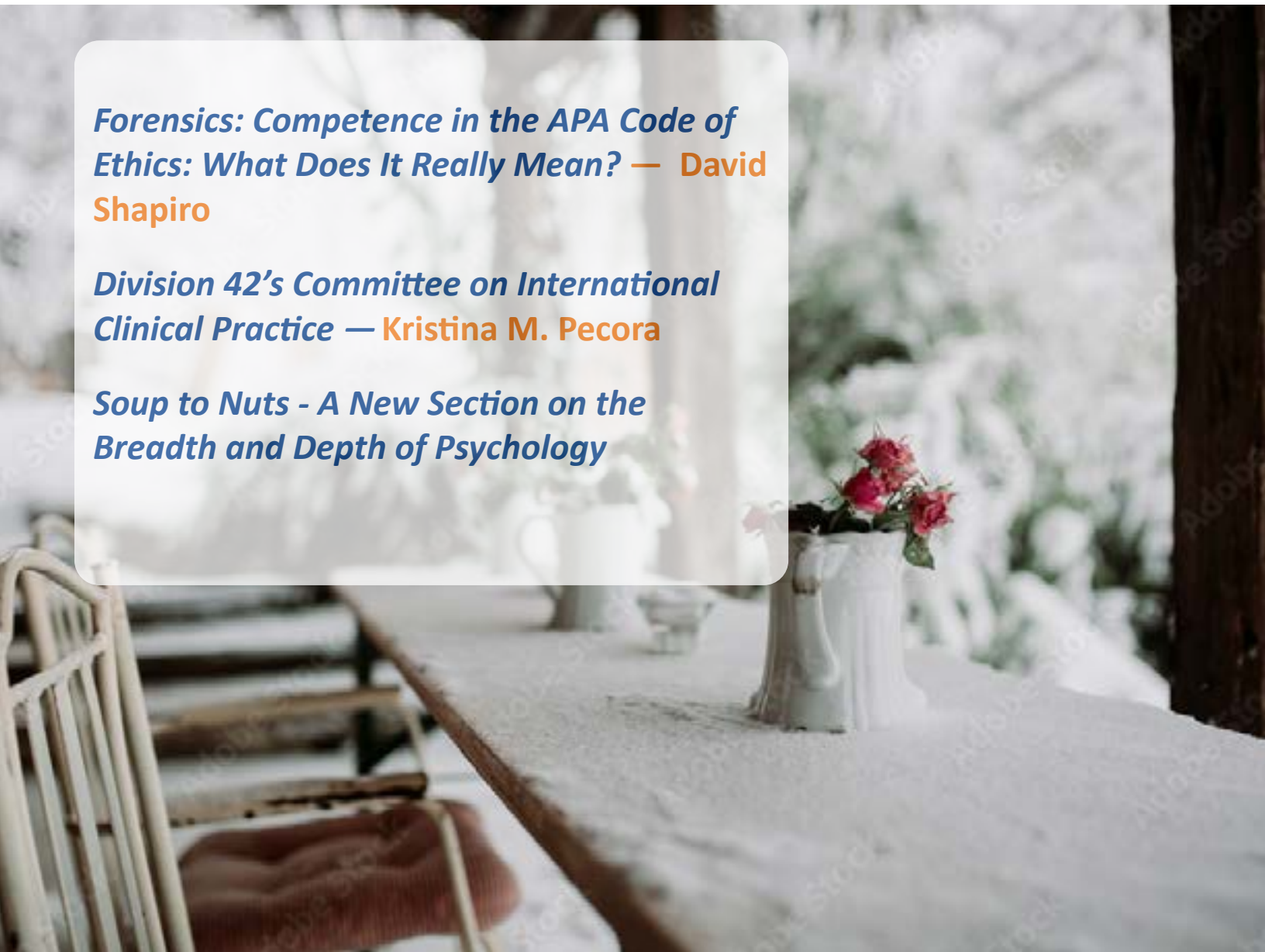
WWW.DIVISION42.ORG



Independent Practitioner

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About the Independent Practitioner

Submission deadlines: February 10 for Spring issue
May 10 for Summer issue
August 30 for Fall issue
November 15 for Winter issue

Submissions:

All submissions (including references) must be formatted in APA style (with the exception that abstracts should be omitted) and emailed as an attached Word file to the Editor and Associate Editor. If you do not have attached file capabilities, mail the disc to the Editor. Hard copies are not needed. Please write two sentences about yourself for placement at the end of the article and provide contact information you would like published (e.g., address, phone, E-mail, web page). Photos are appreciated and should be sent directly to the Central Office. Most submissions should be limited to approximately 2,500 words (6 double-spaced pages), although longer submissions will be considered at the Editors' discretion.

All materials are subject to editing at the discretion of the Editors. Unless otherwise stated, the views expressed by authors are theirs and do not necessarily reflect official policy of Psychologists in Independent Practice, APA, or the Editors. Publication priority is given to articles that are original and have not been submitted for publication elsewhere.

Advertising:

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President's Message

Sustaining Our Practices, Advocacy and Professionalism Amidst Global Crises

Blaine Lesnik

It is no surprise to any of us that we are facing an array of global economic, political, and existential issues affecting all of us in uncountable ways. These issues include climate change, political upheaval, public health challenges, and social injustices. Mental health practitioners and advocates often find themselves grappling with an overwhelming barrage of disheartening news, which can take a toll on their own well-being. It's vital to remember that to effectively champion mental health causes, maintain solid working relationships with our patients and colleagues, we need to maintain our own mental and emotional health. I wish to explore practical strategies for managing stress amid myriad crises, both global and national, while staying energized for mental health practice and advocacy.

By acknowledging the challenging times we are living through, particularly in our field regarding the ongoing conflict in the Middle East between Hamas and Israel, and critical issues here at home, affecting all those in marginalized groups, political upheaval and ongoing mental health crisis, we must recognize that this has created intense divisions within our professional community, which can understandably add to our stress levels. I will discuss briefly how we can navigate these challenges and maintain professionalism while dealing with fiercely divided perspectives.

First and foremost, it's essential to recognize that, as psychologists, when we are with our patients, it is imperative to avoid taking sides and passing judgment on the political and social issues. . Like with any other issue, we try to hold on to what our patients may be experiencing to provide support and care to individuals who may be directly or indirectly affected by these events. This also can be a useful technique to be more empathic with our colleagues who may have strong differing views. An effort to keep our focus on the well-being of our clients and our community is one way to preserve the imperative empathy we must show ourselves, our colleagues, and our clients as we navigate the current tsunami of environmental, political, and social justice issues we face daily.

Another effective way to regulate our stress levels and foster a professional environment is through open communication. We all have encouraged respectful dialogue among ourselves. It's perfectly okay to have differing opinions, but we must ensure that our discussions remain civil and free from judgment. Diversity in perspectives can be enriching and may lead to new insights. These kinds of conflicts can, however, take a toll on our mental health. We all should ensure that we are managing our stress levels and taking time for self-care to stay resilient in the face of these challenging circumstances.

While it may seem rudimentary, I thought it might be useful to list and acknowledge various ways to practice self-care. I often catch myself offering these important "How To's" to my patients, but recognize too, that I am not very good at practicing and making time for them myself. Here are some excellent ways to partake in self-care:

1. Mindful News Consumption

In our age of information overload, it's essential to set boundaries around news consumption. Allocate specific times during the day to catch up on current events and stick to these schedules.

2. Embrace Self-Care

Self-care is not a luxury but a necessity, especially for clinical psychologists. Engage in activities that bring you joy and relaxation, whether it's reading, taking a walk, doing yoga, or spending quality time with loved ones. Regular self-care practices can help you recharge and maintain your emotional resilience.

3. Prioritize Your Well-Being

Your effectiveness begins with your own mental and emotional health. Recognize when you need a break and don't hesitate to seek professional help if you're feeling overwhelmed. Mindfulness, meditation, and deep breathing exercises can help you manage stress and build emotional resilience.

4. Build a Support Network

Connecting with like-minded individuals can be immensely empowering. Join support groups or network with other psychologists to share experiences and strategies. This sense of belonging and support can help you stay motivated and inspired.

5. Take Breaks When Needed

In our digital age, it's easy to become overwhelmed by the constant flow of information, especially through social media. If you find that your mood, energy level or physicality is suffering due to the stress of global crises, don't hesitate to take a break from social media or limit your exposure to distressing content. So many of us have huge responsibilities for others, our patients, our families, advocacy work, it goes without saying that our well-being is a priority.

Advocating and providing therapy in the world now as we are grappling with multiple crises is both admirable and demanding. To sustain our energy, it's vital to prioritize our own mental health. By establishing mindful boundaries, practicing self-care, connecting with others, educating yourself and setting realistic goals, you can manage the stress of global crises while continuing to work effectively with patients, in your community and in the larger world as an advocate.

It has been amazing to watch our division thrive over these last few months during which we also have been dealing with regulatory and legal issues impacting the way we practice, what we must and must not do in terms of meeting ever changing and growing requirements placed on us to continue to practice as clinical psychologists. As a division, we have continued to work toward building a vast library of continuing education, we have had EDI at the forefront of our thinking, served as the Premier Sponsor of the National Practice Convention in D.C. and have managed to share and collaborate with one another consistently and thoughtfully. All of this while having so many pressures placed upon us both internal to our industry and in the larger national and global scene. I am proud of Division 42 and am grateful for the time I spent working with the 2023 Board. I very much look forward to working with the new 2024 Board this year; we have a great year ahead and much to be excited about.

Opinions and Policy

"We Are The Crowd, We're Coming Out. Got My Flash On, It's True"

Pat DeLeon

Licensure Mobility & The Public Policy Process: Alex Siegel, Director of Professional Affairs, Association of State and Provincial Psychology Boards, reports that currently there are 40 jurisdictions (39 effective), out of a total of 55 states and territories, which have adopted and are currently part of the PSYPACT Commission. During the U.S. House of Representatives deliberations on the Fiscal Year 2024 Appropriations legislation, the Appropriations Committee included relevant report language for the Bureau of Health Workforce: "Interstate Licensure. The Committee recognizes that almost 100 million Americans live in a primary care health professional shortage area and over 156 million – almost half of the U.S. population – live in a mental

health care health professional shortage area. While efforts continue to support the recruitment and retention of the health care workforce, optimizing the existing workforce is critical. The Interstate Medical Licensure Compact, created under the Licensure Portability Grant Program, is a voluntary, expedited pathway to licensure for qualified healthcare professionals, including psychologists, to practice in multiple states. Since 2015, the compact has grown from 7 member States to 37 member States, as well as Washington, D.C. and Guam. The Committee encourages HRSA to expand public awareness of these compacts to encourage provider participation." Alex has further noted that an increasing number of the health professions, including APA, have embraced the compact approach. Reflecting upon the recent human-instigated (Maine shooting) and natural (Maui fire) disasters, it would be interesting to know whether the enactment of PSYPACT resulted in additional out of state psychological care for those emotionally impacted by these terrible experiences. Maine has enacted PSYPACT; Hawaii has not.

The House Appropriations Committee also recommended $25 million for the Graduate Psychology Education program, which is the same level as last year's funding. Further, under the Institution of Education Sciences (IES), it highlighted the "Unique Needs of Military-Connected Youth in Mentorship Programs – The Committee recognizes the unique circumstances of highly mobile students, including youth growing up in military-connected families. The Committee supports IES' promotion of mentorship programming tailored to military families' needs." The House further noted its interest in: "Supporting Mental Health Resources for Educational Staff – The Committee encourages the Department to support efforts that promote the mental health and wellbeing for educational staff, including teachers, school counselors, school psychologists, school social workers, and school resource officers."

Former APA President Tony Puente constantly stresses the importance of being personally involved in the public policy/political process, if psychology's voice is to be effectively heard. "What is the Psychology PAC? The Psychology Political Action Committee (PAC) is the bipartisan political action committee of APA Services and a critical entity for all psychologists to be aware of. The mission of the PAC is to strengthen the voice of psychology and psychologists in key policy decisions by supporting the federal campaigns of pro-psychology Congressional candidates through voluntary contributions of our members. Although it represents a vital avenue for our profession to engage in the political/public policy process and successfully advocate for our field's interests, less than one percent (1%) of psychologists give to the PAC [https://vimeo.com/688487752/1cbdc05c1e]."

***Serving the Profession and the Nation* -- A Wonderful Vision and Most Impressive Tenure:** Terry Keane will be retiring as President of the American Psychological Foundation (APF) with Former APA President Melba Vasquez accepting that awesome responsibility. Reflecting upon his dozen years of active involvement with APF, Terry: "This work was one of the high points of my career. Making new friends and cultivating support for the next generation of psychologists is a mission that resonates well with my life's work. That the Board entrusted me with the President's role for some seven years represented a humbling recognition. Seeing the APF successfully manage COVID and the multiple transitions is extremely gratifying to me. APF has a bright future ahead and I look forward to seeing all that it achieves for Psychology and for our communities."

Honoring Female Service Members and Veterans: Long time colleague LTG (Ret) Patricia D. Horoho made history being the first woman, first nurse and first non-physician to become the 43rd U.S. Army Surgeon General and Commander of the U.S. Army Medical Command. Currently, she is the CEO of Optum Serve and Optum Health Solutions, as well as the visionary founder and President of *2Serve Together Foundation*, a nonprofit dedicated to the women who have served or are currently serving our Nation.

Inspired by the pride she would see in the eyes of her father, a Veteran of World War II, Korea, and Vietnam, when people would thank him for his service upon recognizing his ball cap with the three war insignias, it truly showed the tremendous power of a "thank you". It occurred to her that there was nothing that uniquely honored the military service of women. She recently worked with the world-renowned jewelry designer, Ann Hand, to create the **Women of Valor** brooch, a world-wide symbol that recognizes the selfless contributions of female Service Members and Veterans.

Its design is a forget-me-not flower, that is purple to represent a composite of all military branch colors signifying joint service. At its center is a luminous pearl that signifies femineity, and the center star and letter "V" on the tips of the leaves represent "valor", "victory", and "Veteran". When worn, the **Women of Valor** brooch serves as a beacon, sparking meaningful conversation and drawing people in to listen to the inspiring stories of these heroic women – lighting the way for many others to follow in her noble footsteps.

Each woman who has bravely worn the cloth of our great Nation has a rich story to tell about her own journey. While we can never adequately thank them for the breath of their service – an impactful way to take the first step is by seeing them where they are and making a connection by starting a conversation that offers both help and gratitude. To learn more, please visit [2ServeTogether.org].

What Intrigues Former APA Presidents? "Dr. Bob" Resnick:

> "Having reached four score and two years, I often reflect back on my professional life. 27+ years at Virginia Commonwealth University (VCI) Health Center rising to the rank of Professor of Psychiatry and Pediatrics. And at every juncture, i.e., promotion and tenure, the chair of psychiatry interfered. Taking advantage of an incentivized early retirement program offered by the State in 1995, I left VCU. I joined the faculty at Randolph-Mason College, retiring there in 2014 as a Professor Emeritus. It was pure pleasure to be appreciated and accepted. During all but the last four years, I was in practice, reducing it gradually as I headed towards 2014.
>
> "I and my cohort fought legislatively for the statutory recognition of psychologists and the expansion of practice in and outside of our mental health home. For me, it was being the named plaintiff in the precedent setting *Virginia Blues* (1977-1980), a federal antitrust suit ending in the U.S. Supreme Court. It forced the Blue Cross/Blue Shield to reimburse psychologists for care within the scope of their license to practice in Virginia. That Court precedent stopped a planned state-by-state role back of psychologist reimbursement laws. And, it recognized psychologists as independent practitioners needing no supervision.
>
> "My APA service started as the Council Representative from Virginia, then Task Forces authorized by BPA dealing with hospital privileges, member and elected to and chair of BPA, followed by CAPP, the Board of Directors, and President in 1995. And, I was President of Division 42 and 29. One of my 42 Presidential columns titled *Call Me, Dr. Resnick*, generated much discussion over our identity!
>
> "As a practitioner, I was proud that the Council approved, as a matter of policy, prescriptive authority for appropriately trained psychologists during my Presidential year. I was able to attend the DOD graduation ceremony for the first two prescribing military colleagues, U.S. Navy Commander John Sexton and Lt. Commander Morgan Sammons at the Walter Reed Army Medical Center. Finally, after two terms on CAPP, two terms on Council from Division 42, in 2018 I put myself out to pasture. No more APA offices. Now, the annual convention is a time to see old friends and colleagues and attend the Broom Closet dinner for all former Presidents of APA. Rough guess: I was in the APA Governance for about three decades. During those years

and beyond, I played a lot of basketball winning Gold in the Virginia Senior Games and Gold in the Huntsman World Senior Game, while managing to run 40k miles including 5 marathons. My wife Fran, my close friend John Norcross, his wife, and I made annual international trips, tied to professional presentations, and toured 55 countries.

"During my professional years, the practice of psychology has expanded its traditional boundaries of mental health care to become a part of the overall health care system as a primary health care provider in all settings. Prescriptive privileges in seven states with others in various stages of obtaining them are helping to level the playing field for those whose access to care is terribly limited. Psychological care has become fully recognized.

"I could not end these ruminations without a 'thank you' to my wife of 60 years who tolerated and encouraged my professional activities. Truth be told, she enjoyed my Presidential year almost as much as me." ["Dr. Bob" and I had the pleasure of hosting intimate dinners with our APA Convention speakers, Gloria Steinem and Pete Seeger – fascinating experiences.]

Prophetic Messages From the Past: Glenn Ally (February 22, 2005):

> "Just wanted to let you know that on February 18, 2005, the first prescription was written by a civilian 'medical psychologist' in Baton Rouge, LA under the new RxP law signed by Gov. Blanco. Dr. John Bolter wrote the first prescription – a prescription for Remeron (not the trivia folks). This was an historic moment for the Louisiana Academy of Medical Psychology, for the citizens of Louisiana, and for psychology as a profession.
>
> "Having shared the exciting news, I must ask that you not publicize this just yet. In keeping with our attempts to keep most of what we have been doing rather 'low profile,' we do not want this information to get into the press just yet. We have a legislative session beginning in April and we fully expect our opponents to attempt legislation that will somehow limit or restrict our law. While we feel they will not be able to repeal it because of the overwhelming support it received to pass, we believe they will attempt to 'gut it' piecemeal by introducing legislation to pull out certain populations – children, the elderly, pregnant women. We are planning for the fight in case this intelligence becomes a reality. Consequently, we are attempting to avoid drawing attention at this time. I did make the announcement to the Council of Representatives while in executive session and, of course, Russ and Mike Sullivan are aware. Because of your special place in the forefront of RxP, I thought you, as have we, would get particular satisfaction out of seeing a dream become a reality. Aloha, Glenn."

John Sexton (September 2, 2006):

> "I'll move out of my usual lurking position to clear up some recently posted inaccuracies on my study of prescribing rates. Unfortunately, I was not permitted to publish the results of this informal study. I examined 200 randomly selected charts by 2 psychiatrists on patients seen through my outpatient mental health clinic between September 1997 and July 2000. I had seen 965 new patients during that period. All patients were randomly assigned to us based upon the day we had 'the duty'. While most patients were seen in the outpatient clinic, a fair number were seen in the ER or on the medical wards. The patients ranged in age from 17 to 90+ years old. While most were relatively physically healthy, some had significant physical illnesses. The psychiatrists prescribed to 61% and 68% of their new patients, and I prescribed to 12.5%." [John was one of the first two Department of Defense (DOD) prescribing psychologists.] "Cause you know that, baby" (Paparazzi, Lady Gaga). Aloha,

Pat DeLeon, former APA President – Division 42 – November, 2023

Focus on Forensics

Subtleties of Multiple Relationships in Psychology

David Shapiro

While most psychologists are aware of the issues raised by the American Psychological Association's (APA) Code of Ethics regarding multiple relationships, a great deal of misunderstanding exists among psychologists about prohibiting multiple relationships.

The Code of Ethics does not prohibit multiple relationships and it never did. What it demands is that we look out for "harmful multiple relationships." The difficulty, of course, is defining "harmful." The Ethics Code suggested that harmful be considered as any relationship which could reasonably lead to exploitation, loss of effectiveness, or loss of objectivity. There still is a great deal of "wiggle room" here, as there can be relationships that some people would describe as harmful, and others would not. For instance, some psychologists maintain that an impermissible dual relationship occurs when a therapist sees a couple for marital therapy and then sees one or the other of the couple for individual therapy. Other psychologists see nothing harmful in this arrangement. In a similar manner, some psychologists insist that any contact of therapist and patient outside of the therapeutic setting should be avoided, but practitioners such as Zur (2017) talk of the fact that such contact may even enhance the therapeutic relationship. He gives an example of a therapist and a parent who have children playing on little league teams which happen to be playing against one another on some occasion. Rather than avoiding going to the game, the therapist should, in fact, go and cheer on their own child. This can enhance the therapeutic relationship by demonstrating to the parent that the therapist is a "real person."

Of course, there are many situations in which almost everyone would agree that the multiple relationship is harmful, such as sexual encounters between therapist and patient, lending money to a patient and expecting repayment, or being involved in some sort of financial transaction with the patient outside of the fee being charged, such as investing in a patient's company

Another area where there is widespread misunderstanding is acting as an expert witness. An expert in such circumstances is an individual qualified by a judge to render an opinion in a case involving some aspect of mental functioning as it relates to some legal issue. It is important that such an individual, qualified by a judge to be an expert witness understand the parametersof being an expert. This appears, on the surface, to fly in the face of common sense, for shouldn't a therapist know more about a patient, due to years of seeing them in therapy, than a forensic examiner who may see them for forensic purposes on one or perhaps two or three occasions? The answer actually is complex and lies in several areas: the nature of the relationship, the methodology involved in the relationship, and legal issues regarding the nature of privilege. Let us take a look at each of these.

First, a therapeutic relationship is basically different from a relationship for purposes of a forensic evaluation in that it is based on trust. The therapist creates a therapeutic alliance with the patient and essentially deals with the material that the patient presents in therapy without looking at other sources of data for purposes of consistency On the other hand , in a forensic evaluation, there is no therapeutic relationship, there is no therapeutic alliance, and the forensic examiner works to look for consistencies across multiple data sources to reach their conclusions. Doing this in a psychotherapy relationship could well weaken the therapeutic alliance. This is closely related to the next difference: the forensic examiner is expected to be objective, weighing different data sources, while the therapist is not objective. Such objectivity could be perceived by the patient as a lack of concern about the patient's subjective perceptions and a consequent weakening of the trust necessary for the therapeutic relationship. The patient could feel resentful that the therapist needs to "check out " collateral sources. There is always a legal question associated with the forensic evaluation, while that is most often not true in terms of the therapeutic relationship. If a legal question arises when the relationship is a therapeutic one, the therapist needs to limit what has been observed in therapy. For example a therapist may say, based on their observations in therapy, that the children are afraid of their father, but should not make statements regarding custody or visitation.

The nature of the relationship described above also leads to the second difference: one of methodology. In a therapeutic relationship, there is rarely a collection of collateral data, interview with many outside sources, review of records, and extensive psychological testing. Psychological testing, if used at all, is designed to assist in developing a treatment plan, not to develop an opinion on whether or not this patient's psychopathology was relevant, for instance, to their state of mind at the time of an offense. Of particular relevance in a forensic evaluation is the assessment of malingering, or more broadly, response style. Response style seeks to determine whether the person is exaggerating or minimizing psychopathology for the furtherance of some goal in the courtroom. For instance, if a person is exaggerating psychopathology in order to demonstrate meeting the criteria for asserting an insanity defense at trial, this could be a highly relevant piece of information for a forensic examiner. The assessment of malingering should never be done within a therapeutic relationship, because it could raise in the patient's mind the concern that the therapist may not fully believe what the patient is saying.

The final reason for the avoidance of such multiple relationships, lies in the concept of privileged communication. Across all states psychotherapist-patient privilege is an implicit belief that what a patient tells a therapist remains confidential. However, there are certain exceptions to this privilege, such as mandatory reporting of child abuse (and in some states elder abuse as well.)

Another exception is the patient as plaintiff exception to privilege. In this situation, if a patient puts his or her mental or emotional state into litigation (sues for mental or emotional damages) the party being sued (the defendant) may demand discovery of that patient's therapy records, to see whether all of the reported psychopathology stems from the accident or injury at issue or whether it is due to preexisting conditions or some combination of current and prior circumstances. This is also called the eggshell skull plaintiff (Kohutis & McCall, 2020). Still another exception to privilege is when the therapist is allowed to reveal their own records in their defense if they are being sued by a patient or has a licensing or ethics case opened against them The therapist can reveal these records in order to demonstrate that they have, in fact, adhered to the standard of care and not done what the patient is alleging happened.

Yet another exception to privilege is for purposes of involuntary commitment. If a therapist believes that a patient is an imminent danger to self or others, that report has to be shared with someone, for instance, the police or a receiving hospital. Most states also have case law or statute regarding the duty to warn or protect third parties when a therapist's patient has made a credible threat of violence against an identifiable third party. Under these circumstances, the therapist may need to waive privilege and notify the intended victim or the police. Finally, some but not all states recognize a criminal defense exception to privilege. In such cases if a therapist is treating the victim of, or a witness to a criminal act, the defense attorney representing the alleged assailant, may be able, within certain parameters, to get access to the treatment records in order to cast doubt on the credibility of that person as a witness.

In short, there are many exceptions to psychotherapist-patient privilege, and the therapist needs to be careful in discussing these with the patient in their informed consent.

In contrast, when a psychologist (or any other mental health professional) is performing a forensic evaluation, they operate under the "umbrella of attorney client privilege." This is a much broader and more protective privilege, than psychotherapist-patient privilege. The primary reason that an attorney may have to waive privilege is if they know that the client is going to perjure themselves. This, of course, can pose a dilemma for the psychologist who is licensed by a state board and has certain mandatory reporting obligations, and is, at the same time, working under the auspices of the attorney-client privilege, which does not require such mandatory reporting. State licensing boards generally do not recognize differences between mandatory reporting obligations of forensic psychologists working under attorney-client privilege and psychologists who are in the practice of psychotherapy. To further complicate matters, in a recent case from the State of California (Elijah W. v. Superior Court 2013) the Court of Appeals ruled that the attorney-client privilege under which the psychologist was working trumped the mandatory child abuse reporting regulation. In this case, a psychologist was retained by an attorney to do a forensic examination, agreed to be bound by the attorney-client privilege, and would report matters, such as child abuse only to the attorney, and not to child protective agencies. Child Protection argued that the mandatory obligation to report child abuse superseded attorney-client privilege and required that the psychologist be withdrawn from the case. In an appeal, the Court of Appeals disagreed, indicating that the Court was not in a position to override attorney client privilege, and would not consider mandatory reporting as an exception It is unclear at this point in time, whether this reasoning will affect courts in other states. At this time, there have not been any cases in other states that follow the reasoning of the Elijah case. Nevertheless, it is important to keep therapeutic and forensic roles separate to assist in the determination of the privilege under which one is operating. Given the current status of these mandatory reporting requirements, it is recommended that a psychologist performing a forensic evaluation inform the examinee that as a psychologist they still have to report abuse and that can be a factor that the examinee may want to consider before consenting to the evaluation.

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Division 42's Committee on International Clinical Practice: Connecting clinicians globally to innovate our practices, expand our perspectives, and broaden our networks of support.

Kristina M. Pecora

In January 2023, Division 42's Board voted to officially create the Committee on International Clinical Practice (CICP), moving the group from an initial Taskforce to a more stable group. Since then, we have had a year of action and advocacy.

CICP consists of practitioners with deep knowledge in the areas of regulation, licensure by international organizations, domestic and international telehealth policy, and interjurisdictional practice. This past year, our members presented their research at international conferences including the European Congress of Psychology and the European Economic and Social Committee annual meeting, rallied to support refugees from Ukraine, and worked with APA's Division 52, International Psychology, to expand resources on how to practice internationally. We even created some handy infographics on what to consider before practicing in another country. Check out the print/digital version in this *Practice Innovations* issue.

Allow me to feature a few of our Committee members here:

Elaine Ducharme is a private practice psychologist in Connecticut, and the founder of Division 42's International Psychology Taskforce. She will be presenting with a team of psychologists and attorneys at the International Association of Law & Mental Health Congress in July 2024 on the impact of personality disorders in divorce, and how professionals can understand and manage these cases.

Alan Entin, a psychologist and photographer, has explored the intersection of art and psychology in his work as a family psychologist in Virginia. He has held leadership positions in APA and its divisions throughout his career. Most recently, his artwork was featured on the July-August cover of *The American Psychologist*.

Julien Perille is a private practice clinician in Maine. Additionally, he is involved in the non-profit organization Resilience Building, where he works with professionals seeking to build more resilient communities for the Immigrants and asylum seekers from Africa in the Portland area.

Diana Prescott, a leader in international clinician circles and APA, presented a new consulting model for working with healthcare executives in managing pandemic stress and burnout through facilitated dialogues at the European Congress of Psychology in Brighton, England, Summer 2023. The presentation highlighted the utility of psychologists' skills for providing interventions when the need is immediate, urgent, and in circumstances where previous research or pilot testing is not feasible.

John Francis Leader (JFL) focuses on mental health and digitalisation through practice, research, policy and outreach in Ireland, Europe and the United States. He actively participates in international advocacy. He recently spoke at the European Economic and Social Committee (EESC) on the topic of 'Young people and mental health': https://youtu.be/cHOd-QqLxyR0.

Members of the Committee who we hope to feature in future articles include Lenore Walker, Kent Rude, Alex Siegel, Morgan Sammons, Elizabeth Carll, and Maria Corrigan. The Committee is supported by the incomparable Jack Hutson.

The Committee's main goal is connecting clinicians here, there and everywhere for collaboration and camaraderie. To meet this goal, we hosted two fireside chats in 2023. These informal meetings were open to Division 42 members as well as clinicians outside of the Division with similar interests. In March, we addressed issues related to the returning to offices after the COVID pandemic state of emergency. While turnout was small, the discussion was rich as we shared anxieties, innovations in using telehealth, and the push-pull of wanting to get back to "normal" but also feeling comfortable in a virtual environment.

The second fireside chat, held in November, focused on "Anxiety in You and Your Clients". Thirty-five attendees from locations around the US as well as Egypt, Ireland, and Argentina came to discuss topics as broad as telehealth regulation, the Israel-Palestine conflict, and how anxiety manifests in clients in different locations. The discussion was lively, and many of the participants commented on the positive, collaborative energy of the group.

In the coming year, we plan to host one fireside chat each quarter as well as supportive consulting and networking groups. Members of the Committee will answer your questions here in a regular Independent Practitioner column!

We have created a listserv for anyone interested in international clinical practice to join - DIV42_INT_CLINICIAN_FORUM@lists.apa.org. This listserv is open to Div42 members *and* nonmembers, across degree level and experience, from locations all over the world. It's a gathering place to find information on what is happening outside of our home offices and virtual spaces. We envision the listserv as a community of practice and shared thought in an environment of ever-increasing mobility. We see it as a space where you can find clinicians who practice where a client may be moving, or for information on licensure across country lines so you can move abroad and still practice.

We invite you to join us on the listserv! It is only as interesting and active as its members, so we are trying to get as many professionals to sign up as possible. Simply email div42apa@gmail.com with the subject **"I am an international-ist - put me on the list!"**

Kristina Pecora is a licensed clinical psychologist in private practice in Chicago, Illinois where she specializes in health psychology, trauma and resilience, and global mental health. She has worked internationally with US military service members and Kenyan border police officers to promote health behavior change and wellbeing. She actively advocates for mental health access in the US and abroad.

How De-Identification Has Turned HIPAA on Its Ear (And Other HIPAA Tidbits Pertinent to Those of Us in Private Practice)

Susan C. Litton

Is It Possible to Be Exempt from HIPAA in 2024?

As soon as I answer "No" to that question, someone would write me, explain their situation, and I'd find myself in the position of needing to write a retraction. So let me just say that at this point in time, I'd be hard-pressed to come up with a scenario of how one might pull that off.

In the past, YES. When HIPAA was enacted in 1996, some psychologists and other healthcare providers opted to abstain from actions that would trigger HIPAA. They kept only paper-pencil records, refraining entirely from creating or storing digital files on any device. They never submitted insurance claims electronically. By taking these precautions, they did not consider themselves to be Covered Entities (CEs).

However, when COVID began, many providers, who had never used electronic tools, felt that taking the digital plunge had become necessary. They started by using video software but may soon have found themselves needing other tools for routine tasks. Although some discretion was allowed in the early stages of the pandemic (Office for Civil Rights [OCR], 2020), providers were encouraged to get HIPAA Compliant products that provided Business Associate Agreements (BAAs), as soon as possible. At the time, getting a BAA was considered "best practices". However, this is the issue:

BAAs are legally binding contracts, but ONLY for Covered Entities. They almost always start with a statement similar to this:

"This document is an agreement between X, a software company and Y, a Covered Entity."

If you've signed a document like that that attests to the fact that you ARE a Covered Entity, you might have a hard time convincing an auditor or a court that you are not. It only takes one such signed document to flip the switch. Once HIPAA is triggered, it's triggered – it can't be undone. There ARE some exceptions when HIPAA Does NOT Apply, such as when the information doesn't constitute PHI, when it's used for specific research or public health activities, or when it's handled by certain entities like schools, employers, or law enforcement. But unless you fall into one of these categories, it's likely safest to assume that you're a Covered Entity.

There's also a somewhat nasty double-bind here:

- If you claim you're NOT a Covered Entity, your BAA is null and void since BAAs only apply to CEs.
- However, if you ARE a CE, you're required to comply with HIPAA.

Not long ago, I would now point out that becoming compliant with HIPAA didn't have to be a heinous or expensive task. Whether you would want a BAA was almost a no-brainer, since BAAs were intended to provide additional peace of mind for both providers and their patients. My suggestion would have been to just bite the proverbial bullet, become compliant with HIPAA, and continue using HIPAA Compliant Software that provided BAAs. However, recently, some healthcare software companies have reworded their BAAs in ways that are contrary to how BAAs were originally intended to be used. Here's the story:

BAAs: What They Were Intended to Be and What They've Become

The concept of a "Business Associate" (BA) was introduced in HIPAA's Privacy Rule in 2002 and 2003 as "a person or entity that performs certain functions or activities that involve the use or disclosure of protected health information on behalf of, or provides services to, a covered entity" (OCR HIPAA Privacy, 2002, 2003). The definition was expanded in 2009 by the Health Information Technology for Economic and Clinical Health Act (HITECH), requiring BAs to comply with many of the same privacy and security requirements that apply to CEs. The HITECH Act also required BAs to provide CEs with Business Associate Agreements. Finally, the Omnibus Rule of 2013 extended a BA's responsibility to safeguard a CE's Protected Health Information (PHI) such that if there was a breach caused by the BA's company or product, the BA was at fault, not the CE. BAs were also required to specify how they used and intended to use the PHI that had been entrusted to them.

The intent of these laws was to encourage software developers to build secure healthcare products. The logic was that if a company knew it would be held accountable, it would offer safer products and services. It was hoped that the requirement of transparency would encourage ethical business practices. The original purpose of a BAA, then, was to provide a layer of protection for CE and their patients.

Recently, however, certain healthcare apps, including at least one EHR, had to revise their Terms of Service because of updated privacy regulations required by certain states. To meet the new requirements, these companies altered their Terms of Service and BAAs. Although the changes they made were legally compliant, the companies no longer offered the same level of assurance for CEs. In fact, the new Terms did just the opposite. The key to how they managed to do this has to do with de-identified data.

De-identification

De-identification of PHI, by itself, is neither good nor bad. The issues are more about how it's done, whether it's done correctly, and the purpose for the de-identification. We'll look at each separately.

How De-identification is Done

HIPAA is quite clear about how to de-identify data. There are two methods that can be used. The one used most often, which also produces the best results, is called the Safe Harbor Method. According to the provisions outlined in HIPAA's §164.514(b), the Safe Harbor Method for de-identification lists the following 18 identifiers of the individual or of relatives, employers, or household members which must be removed:

A. Names

B. All geographic subdivisions smaller than a state, including street address, city, county, precinct, ZIP code, and their equivalent geocodes, except for the initial three digits of the ZIP code if, according to the current publicly available data from the Bureau of the Census:

   1. The geographic unit formed by combining all ZIP codes with the same three initial digits contains more than 20,000 people; and

   2. The initial three digits of a ZIP code for all such geographic units containing 20,000 or fewer people is changed to 000

C. All elements of dates (except year) for dates that are directly related to an individual, including birth date, admission date, discharge date, death date, and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older

D. Telephone numbers

E. Vehicle identifiers and serial numbers, including license plate numbers
F. Fax numbers
G. Device identifiers and serial numbers
H. Email addresses
I. Web Universal Resource Locators (URLs)
J. Social security numbers
K. Internet Protocol (IP) addresses
L. Medical record numbers
M. Biometric identifiers, including finger and voice prints
N. Health plan beneficiary numbers
O. Full-face photographs and any comparable images
P. Account numbers
Q. Any other unique identifying number, characteristic, or code, except as permitted by paragraph (C) of this section; and
R. Certificate/license numbers

That SOUNDS like it should be straightforward, but it's not. One issue is that medical records are a combination of structured and unstructured data (also called "free text"). De-identification software products used to scrub medical records and remove identifiers are reasonably good at detecting and removing PHI from structured data. However, PHI in free text sections are not always clearly labeled (Dorr et al., 2006; Uzuner et al., 2007). This might mean, for example, that the clinical notes we enter into our Electronic Health Records or other note-taking software could be treasure-troves of identifying information, even when we're reasonably careful with how we write them. This is because, except for structured questions in the notes, the notes we write would be in free text areas of the application. Another place de-identification software could easily miss identifying information would be on files or forms a therapist might upload into their file storage application or that portion of their EHR. Those kinds of documents – typically PDFs or Word documents – often contain all sorts of information, including assessment results, that could be harmful to our patient if it were to get out.

Whether De-identification is Done Correctly

The difficulty with the de-identification process described above illustrates problems that occur when de-identification is done correctly. However, we may be taking too much for granted when we assume companies are doing it right. For example, some companies claim to use initials to identify patients, citing that as evidence that they're de-identifying PHI (Dalton, 2023). However, according to HIPAA, initials are considered PHI when those initials are maintained in a designated record set (U.S. Department of Health & Human Services, n.d.). It is unclear whether the companies doing this are unaware of correct de-identification practices, or whether they are choosing to ignore them. Either way, each potential identifier that is NOT removed increases the possibility of recognition. De-identified data is not considered foolproof. Even when it is done properly, individuals can sometimes be recognized (Benitez, 2010; Sweeney, 2000). However, even though de-identification doesn't ensure complete protection or confidentiality, it IS legal and – most importantly for our discussion – de-identified data is no longer considered PHI.

The Purpose for De-identifying the Data

This final discussion point – the purpose for de-identifying data – is what has thrown HIPAA on its ear. The issue is not that companies are de-identifying data. It's the rights the companies are assigning themselves by doing it. Companies are claiming that they de-identify all PHI they receive from their subscribers. De-identified data is not considered PHI. The companies argue that because they de-identify all data, the following assertions are true:

- All data entered into their program belongs to them (since they de-identified it, it is now their data, not your PHI).
- As a result, they can do anything they want with it – sell it to any buyer they can find, use it to train AI models, etc. Furthermore, they refuse to disclose how they use this data. It's their data to do with as they please. The fact that the data has been de-identified, they argue, puts it in the realm of an internal business decision, and they are not required to disclose such practices to their customers.
- This may also mean that they are no longer on the hook for breaches. Breaches apply to PHI, but de-identified data is no longer considered PHI. Any mishaps that occur with de-identified data fall into the "unfortunate accident" category. Your clients may have been part of the unfortunate accident – possibly even been identified from it – but it's not a breach. Because it's not a breach, there's nothing the company must do to remedy the situation or try to prevent it from happening again. But what if there IS some kind of incident where patients are identified. What are your legal responsibilities or ethical considerations? Or what if you enter data into the program in the afternoon, the company does routine de-dentification sweeps every night at midnight, but there's a breach during the window before the data was de-identified? Who's responsible for that?

Miller, 2021, further discusses this problem by noting that "de-identified data can easily be re-identified when combined with other datasets, and the only protection from re-identification right now is the recipient of the data agreeing to not do so." In the case of the software companies described above, we clearly do not even have this much. In fact, they are specifically asserting that they do NOT have to tell us what they are or aren't planning to do with the data we enter into their programs. Companies they sell our data to would be within their legal rights to re-identify it.

Clearly BAAs like this, originally intended to help us, no longer do so. Some providers have mistakenly concluded that since these companies are still claiming to be HIPAA compliant, they do not need to worry about the new Terms. This is wrong for several reasons.

HIPAA Compliant Software?

First, technically speaking, there is no such thing as HIPAA compliant software. Software cannot be a Covered Entity, and only CEs can be HIPAA compliant. Using "HIPAA compliant software," means that, assuming you use it correctly and are complying with all other HIPAA requirements, YOU, as the CE, can be in compliance with HIPAA.

Second, although the OCR indicates that healthcare software should be encrypted, it doesn't specify the type of encryption that must be used. This was a wise move for two reasons:

- Technology is constantly changing. Specifying cutting-edge encryption available when HIPAA was enacted on August 21, 1996, would have quickly become outdated.
- The authors of HIPAA were not experts in technology. By not specifying the type of encryption, they were leaving those kinds of decisions up to the experts in the field, which is as it should be.

However, the fact that the type of encryption is not specified has also allowed software developers a great deal of latitude. Some companies, for example, knowingly use encryption that is only secure 80 - 85% of the time (Google Transparency Report Help Center, n.d.). This is legal. Although a bit on the absurd side, technically, if a product is only encrypted 10% of the time, the BA has still fulfilled their HIPAA obligation. When we put this fact together with data that may be incompletely or inaccurately de-identified, the likelihood that our client's data may not be adequately protected by companies using these new all-inclusive Terms is very much in question.

Ethical Considerations

Although companies doing this may well be operating within the law, are they ethical? Can you use these products and still maintain the ethical standards of your profession? All healthcare professions have ethical codes concerning confidentiality. The American Psychological Association's code of ethics, Section 4, Privacy and Confidentiality, includes two standards that are especially pertinent here: 4.01 Maintaining Confidentiality and 4.02 Discussing the Limits of Confidentiality.

These two standards specify that psychologists "have a primary obligation and take reasonable precautions to protect confidential information obtained through or stored in any medium." Furthermore, psychologists are to discuss with their patients "(1) the relevant limits of confidentiality and (2) the foreseeable uses of the information generated through their psychological activities (American Psychological Association, 2017)."

In a blog post by Dr. Keely Kolmes (2023), they provide compelling evidence that using such products may well put us in violation of our ethical guidelines ("It had to be you: When your favorite EHR makes you break up with them," 2023). In addition to confidentiality issues, Dr. Kolmes references APA standards pertaining to the general principles and informed consent.

Conclusion

Although Dr. Kolmes' post pertains to a single product, Simple Practice, my concern is that other products will follow suit, if they have not already. Zoom originally released new Terms that were similar to those released by Simple Practice. After only a few days of receiving a rather large outcry of negative reactions, Zoom reversed their position and instead stated that Zoom healthcare products would be excluded from the new Terms. Simple Practice has made no such retraction. Other companies are mostly remaining mute – leaving me to wonder what I would find if I were to read the current Terms and BAAs of other similar healthcare products.

Obviously, those of us in healthcare professions have no control over the business decisions software companies make. However, our primary responsibility is, and always has been, to the patients, students, and other individuals we serve. The following guidelines may be useful:

- I still recommend using HIPAA Compliant Software that provides a BAA. However, read the BAAs. Don't just assume the company has your best interest at heart and sign. Although that might have been reasonable at one point in time, it no longer is.
- Integrated products such as EHRs may be better choices than stand-alone products, partly because you'll have fewer BAAs to try to make sense of and, thus, fewer potential loopholes.
- When feasible, use products that specify that they do not sell, barter, or trade any patient data, even in de-identified form.
- Special precautions should be taken with products that might use patient data to train AI models, including those that maintain that they will not disclose what they're using your data for.
- If you do choose to use products that are putting your data at more risk, consider discussing this increased risk with your patients, possibly also giving them other options if they do not consent to having their data used in that way.

Unfortunately, I don't feel there are perfect solutions to this dilemma. Although it is still possible to find products that do not de-identify and sell PHI, if you're already heavily invested in a product that does, it may be overwhelming to consider transferring to a safer product. APA's ethical standards require us to "take reasonable precautions" with patient confidentiality. The definition of "reasonable" is a decision each professional will need to make for themselves.

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Op-Ed

Become a Voice of Independent Practice and Run for an APA Board or Committee

Alan D Entin

Division 42 Past-president Peter Oppenheimer sent an important email to our membership, which, unfortunately, is only a fraction of total division membership. It carries a message that is of vital importance to the practice community and bears repeating and amplifying because it requires immediate action. I responded to Peter's post. Eileen Kohutis, IP Editor, thought the issue was of important to the entire membership. She requested I expand on my comment for the magazine to notify and to solicit the participation of the entire membership of the Division. The issue is nominating and electing practitioners to the governance of APA.

Peter wrote: "Service on an APA board or committee is a great experience and a valuable contribution to the profession. It is important that Division 42 members represent the interests of independent practitioners in these groups. We encourage our members to stand for election and serve." APA is also running a series of ads with the same message: Become involved in the governance of APA. Nominate yourself and/or a colleague to APA boards and committees.

The deadline to do so is NOW!

On our listserv and at various Division 42 committee meetings, there have been discussions about the lack of participation in APA governance and the corporatization of APA, as well as whether or not APA represents the interest of practitioners, the role of EDI in APA.] While I am not taking sides, I am hoping my urging of your becoming involved in governance, amplifying the voice of practice, will lead to a more involved member discussion of the issues involved. I am urging you to nominate yourself and other practitioners for the various APA Boards and Committees, as well as for the Presidency of APA. I think it is shameful that APA Council put forth a motion to approve a reduced slate of nominees, reducing APA presidentom a slate of 5 to 3 nominees for the Presidency of APA, presumably because the committee could not find enough candidates to fill the slate, a shameful situation that so few qualified individuals wanted to run for APA president

Division 42 should form coalitions with other divisions in the practice community. We used to do that, and our members were elected, and our goals made it to the APA agenda. Academics did it, and their goals became the goals of APA. Other groups and interests are doing it now, and their goals have become the goals of APA.

Our goals are not high on the agenda. There is no unified or amplified voice of practice. APA Council used to have many different caucuses, for example, education, practice, states associations, science, who were lobbying groups for their specific interests or for political purposes to support legislation or APA division interests. I do not know whether these caucuses still exist or their effectiveness. Certainly, we must take action to nominate and elect practitioners.

Instead of being critical of the system, we must take action ourselves and nominate and vote for practitioners. Peter's message is clear: "It is important that Division 42 members represent the interests of independent practitioners in these groups. We encourage our members to stand for election and serve."

We have to be proactive on our behalf… and to do that we need to be represented on APA Boards and Committees. We need practitioners to volunteer to promote practice. Nominate yourself, get your colleagues to nominate you and nominate your colleagues for Boards and Committees. Work with other Divisions to elect practice candidates.

The cause is important: the survival and flourishing of independent practice. And the deadline is now! Contact Peter Oppenheimer if you have questions at pmoppenheimer@bbhsri.com. The deadline for nominations is January 31, 2024, for service on boards and committees in 2025-2027.

I am a founder of the Division and have served as Council Representative from Divisions 42, 43 and 46, many times. In addition, I served as President of the Divisions of Independent Practice, Family Psychology, Media Psychology and the Virginia Psychological Association. I am a Heiser Award recipient for my advocacy activities. For these reasons, I understand the importance of involvement in the Division and in APA.

I will close with a slight twist on the close to ending of Peter's letter. I hope you will strongly consider service to the Division, Independent Practice, and APA by standing for nomination to an APA Board or Committee. Please let the Division know by emailing our Executive Director, Jack Hutson, at div42apa@gmail.com . We can help you navigate the nominations and elections processes. Please, let Peter know if you have any questions. His email is pmoppenheimer@bbhsri.com. I can be reached at dralanentin@gmail.com. The deadline for nominations is January 31, 2024, for service on boards and committees in 2025-2027.

I am a licensed clinical psychologist in Richmond, VA, and have been in independent practice for over 40 years specializing in family systems psychotherapy. I am an artist and my photographs have twice graced the cover of the American Psychologist. I am a recipient of the American Psychological Association's Rosalee Weiss Award for contributions and leadership in psychology and the arts.

Book Review

The Thriving Lawyer: A Multidimensional Model of Well-being for a Sustainable Legal Profession.

Book Review by Eileen Kohutis

Cipriano, Traci. (2024). *The Thriving Lawyer: A Multidimensional Model of Well-being for a Sustainable Legal Profession.* Informa Law from Routledge. 207 pages.

Traci Cipriano, psychologist, and former practicing attorney, combines her insight and knowledge of psychology and law to present a multidimensional model about how attorneys can sustain their well-being. Although her model is focused on attorneys, there are numerous insights and suggestions for psychologists as well. In her model, she explains how the individual attorney and legal community have each played a role in creating the quandary that the legal profession faces today and what each can do to remediate the situation. That is, how to create a healthy work-life balance?

As a former lawyer herself, Cipriano has intimate knowledge about the way that law firms function and about the legal culture itself. Acknowledging the legal culture maintains circumstances that foster competitiveness and meticulous accuracy, it also needs to address its role in needing to create a healthy work environment. Here, too, she offers recommendations on what firms can do to foster such an environment.

The legal profession has little room for error; competition and perfectionism coexist with anxiety, depression, substance abuse, and burnout. While this field attracts people who tend to be competitive and perfectionistic, these traits also are honed in law school. And it is here where people learn to suppress showing emotions because emotions are viewed as a sign of weakness. Yet, it is this suppression of emotions that causes many lawyers to utilize unhealthy ways of living which, in turn, take their toll on the individual and the field itself.

Cipriano's model encompasses the interplay among work-life balance, physical and mental health, the work environment, personal relationships, and financial resources. Discussing the complex ways that each of these factors affect the individual and the legal community at large, she employs numerous studies, scenarios, and examples that make the reading come alive. She explains psychological concepts and provides their application with straightforward suggestions and tips for implementation to deal with some of the stressors. For example, she discusses how stress affects a person and then provides the reader with self-care tips, such as practicing yoga and doing guided imagery. She then states that overwhelming stress may lead to depression, anxiety, cardiovascular issues, sleep disorders, and substance abuse.

Cipriano is practical. She states that just as individual well-being does not just happen overnight, neither will well-being in the legal community happen overnight. To this end, she offers suggestions for both the individual and for the legal community. She maintains that learning to take care of oneself is a process and that individuals need to take time to make this a priority. Her no-nonsense approach is to begin with small, achievable goals that can be built upon. She maintains that while an individual may be able to take control of his or her own behavior, the law firm needs to also make

changes in its approach to employees.

Rather than give long recitations or detailed information from various studies, Dr. Cipriano introduces terms and concepts that are very familiar to psychologists. Yet she presents the information in a clear, informative, and conversational tone. This is not to minimize what she says, but rather to highlight the relevance of the material and her masterful command of the topic.

The structure of the book is appealing as well. Throughout the book are little vignettes that clearly illustrate Cipriano's points and each subject flows logically to the next one. Each chapter has a sizable reference list. The Appendix, like the rest of the book, has resources for the individual lawyer and the legal community.

In case you were wondering why the *Independent Practitioner* would publish a book review about self-care for lawyers, self-care is not an alien concept to psychologists. Indeed, it is a concept relevant for all of us—especially in these times (and in keeping with the rest of the articles in this issue). While, as psychologists, we may not face the same pressures that attorneys do, we experience our own unique work-related pressures, and need to engage in self-care for ourselves. When we engage in our own self-care, we demonstrate that practice and priority to our patients as well.

Practice Innovations

Call for Submissions

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Soup to Nuts: The Breadth and Depth of Psychology

Working outside the box

Stepping Out of the Insurance Dance

Dana C. Ackley

If you are taking time to read this, you've probably found yourself frustrated with the constraints and complications of dealing with health insurance. Is there another way to do what you want to do professionally? There is. But fair warning, you will be highly tempted to disbelieve what follows.

First, if you have been in practice for a while, you may have accommodated to the system. It feels "normal – just the price of doing business." Everyone seems to think like you do, including APA. You may think: "If all of these smart people think that this is how things have to be, who am I to question it." (And yet you teach critical thinking to your patients every day.)

Second, there is the Sunk Cost Fallacy. You have invested time, energy, and money in achieving your current level of success. No one would want to believe that so much of their effort was unnecessary. You have not wasted you time. You have created one level of success for yourself and your patients. Now may be the time to take off the constraints. You will become an even more effective therapist and earn a better living by doing so.

Insurance for mental health treatment is an abusive system, not just to you but to your patients as well. You may feel as trapped in the system as an abused spouse. You might point out to an abused spouse that (a) what they are feeling isn't normal, i.e., most people don't live that way, and (b) some of the ways in which they are being hurt beyond the obvious. Similarly, there are some things that those who have felt that they had to accommodate to the insurance system may not know.

For patients:

- The money that patients save by using insurance often becomes a net loss for them. The money may be clawed back by higher health and life insurance premiums that go on for a lifetime[1].
- Patients may be denied certain employment/career opportunities if they carry a psychiatric diagnosis.
- Patients may feel the need to "life up to" a diagnosis they have essentially been paid to have, putting a barrier on progress.
- Patients may feel the stigma that our society places on psychiatric patients. Most people who show up at your office struggle with self-regard as it is.

For therapists:

- The healthcare system generates/exaggerates practitioner fears about being tossed from panels, HIPAA violations, state board complaints, and malpractice suits. It is hard to be one's best therapist when dealing with constant high anxiety.
- Therapists are badly underpaid compared to the value they provide. You may have lost track of the tremendous and rare value you have.
- Brave and hard-working therapists have tried to impact/change the insurance system for thirty years. I can assure you

1 An interesting exercise might be to figure out how much patients actually save. Let's assume a $150 hour rate and 26 sessions. Total cost is $3900. If they have a 50% copay, then insurance pays $1900. How does what patients have to give up for this "benefit" compared to the advantages of not using insurance?

> that the issues that get discussed on the listserv today are no different than issues we dealt with in the mid-1990s.

Let's suppose that you are now thinking: "OK Dana. I'm convinced. I'm motivated. I want out! But I don't know how. What do I do?" First, read the rest of this article. Then, for a more complete explanation of what follows, read ***Breaking Free of Managed Care*** (Ackley, Guilford Press, 1997) (I no longer get royalties.) Reading ***Breaking Free*** will give you a more detailed explanation of how therapists got into this situation, why it doesn't bring out your best, and step-by-step methods to extricate yourself from the "system." Yes, it is an old book. But those who have read it recently tell me that it is just as relevant today as when it was in 1997.

Practice what you preach to patients: As you read what follows, you will have significant doubts because it goes against what has become conventional thinking. First, doubts are useful. When you are in therapist mode, you call it resistance and recognize that it is a normal and necessary part of learning. Just don't let doubts and questions freeze you. Let them spur you to do your own research and critical thinking.

Second, recognize that the true barriers to change are mostly in your own mind. How do I know? Partly projection - that's what was true for me. But there is more data. In addition to writing ***Breaking Free***, I conducted 50 or so workshops around the country. Sponsors included Division 42 (which made me a Fellow in response to my model) and about fifteen state psychological associations. Many readers of the book and participants in the workshops wrote to me, confirming my own experience. (We had a newsletter in which people shared their experiences.) We'll get back to some of their observations.

Remember that you tell patients the same thing every day that I'm saying to you. To make the changes that your patients need to make, they have to tolerate a certain degree of anxiety associated with change, while avoiding the paralyzing anxiety that has trapped them for years. You face the same challenge.

The transition takes hard work. But it is easier now than in the late 1990s because you have scouts like me who have done it. It took me about three years to shift from the kind of thinking that kept me addicted to health insurance to thinking that led to true independence. Division 42 says it is the Division of Independent Practice, but those ensconced in the health insurance system know precious little true independence.

Here are some erroneous beliefs that you will need to change:

People can't afford therapy without health insurance. Don't tell that to the many therapists who have left the insurance system behind. The truth is that 80% of people can afford to pay out of pocket. But psychologists, and the insurance industry, have trained people to think they can't afford it. When people have a chance to be educated about (a) the disadvantages of using health insurance and (b) the value therapy provides, they gladly pay.

People, including your patients, make buying decisions every day, just as you do. I learned in my research for ***Breaking Free*** that every buying decision comes down to two and only two factors - value and cost. Which takes precedence depends on what is being purchased. Cost is the most important factor when you are buying a commodity, that is, when the value of something doesn't really change based on its source. If you can save ten cents a gallon at one station over another, it makes sense to pay less. It's the same gas.

But it also makes sense to pay more when you get more value by doing so. If your child needs surgery, do you look for the cheapest surgeon or the one with experience and a stellar track record? As I read the posts on the Division 42 listserv, it seems clear that most therapists have lost track of the immense value they provide. People are trusting you with their quality of their lives. You are not selling a commodity. But because we were not trained in how to think about business, psychologists have allowed themselves to be manipulated into going to market on the basis of cost rather than value.

Psychologists and their patients have suffered for it.

Here are some data to consider. When my practice was insurance dependent, it served people from a wide span of socio-economic status. That didn't change when I made my transition. Countless therapists who read ***Breaking Free*** or came to workshops wrote to me confirming that this was their experience as well.

And there is this: Workshop participants who lived in big cities would say, as a part of their resistance: "People in small cities like yours might pay for therapy out of pocket but they won't here!" (They had never actually tested that theory.) Participants who lived in rural areas would say "People in big cities might pay out of pocket but out here nobody would." But that's not what therapists told me who had implemented insurance free practices told me. Here is perhaps my favorite quote:

> "I have a very poor, very blue-collar, very rural, very uneducated, very non-mobile, very horse-shoe-throwing, Budweiser-drinking, pregnant by 17, gunrack-in-every-pickup, ultra conservative, bigoted, red-necked population and they still choose this model!"

Getting comfortable with making money: You are a helper, or you would not be doing what you are doing. Helpers are often uncomfortable asking for something for themselves. But the truth is that helpers are better helpers when they also see to their own well-being. That includes making enough money to sustain what you consider to be a comfortable lifestyle.

With that in mind, one step in moving out of insurance dependency is to determine what your new rate will be – your real rate, not the discounted rate insurance companies make you take. Doing so may mean that you have to struggle with your attitudes about money. It can be a very emotional topic. When you do the work of dealing with your own money attitudes and beliefs, you will be a much better therapist for people who need to do the same. It can help to recognize that, at its core, money is nothing more than a tool that humans have devised to exchange goods and services. Yes, it can take on all sorts of meaning, but it doesn't have to.

Struggle a bit with these questions: What are your income goals? How much income do you need to support what you consider to be a comfortable lifestyle? How much extra do you need to handle long range goals such as paying for your children's college, buying a home, and saving for retirement? If you set your income goals too low, you will feel put upon, which will impact your relationships with your patients. If you set them too high, you will feel greedy, which will impact your relationships with your patients. You are the only one who can make the decision about what fits for you. I would just encourage you to charge enough to communicate to your patients that you highly value what you do, which will encourage them to do the same. As a result, they will be more committed to the process and get more out of it. People tend to value what they pay for.

An approach to fee setting that I used was as follows: I figured out what I wanted my annual take home pay to be, given the factors cited above. Then I totaled up my practice expenses. Those two figures gave me a gross income goal. Then I figured that I would see 30 people a week, 44 weeks a year, which came to 1320 clinical hours. That gave me six weeks for vacation, sick days, continuing education, no shows, etc. Finally, I divided my gross income goal by 1320 hours, which gave me a basis for setting a fee. Remember, sell your time based on the value you provide. If you are the low-cost alternative, people may show up, but they won't value what you provide enough to do the hard work.

The Medical Model Is Reality: No, it isn't. It is a model! It is just one way of understanding human problems, and, in my view, a poor way at that. Psychologists have many other theoretical models with much more utility to help people solve the problems they ask for help about. None of those models require a psychiatric diagnosis. Those alternative models, which you also use when you are really helping people, require a deep understanding of human behavior, not inadequate boxes to stuff people into.

You might be saying "I've used the Medical Model for years. I don't see the problem. What is wrong with it?" I'm glad you asked. The answer? "Lots of things." Based on extensive research that I did preparing to write ***Breaking Free***, here's what I learned:

First, there is precious little science behind the DSM. For example, a key principle of science is parsimony. When I earned my Ph.D. in 1973, there were 35 diagnoses in the DSM. When I stopped relying on insurance payments in the mid 1990s, the then current version of the DSM had over 800 diagnostic choices. I often joke that I could diagnose a ham sandwich. The DSM has grown as it has followed the (insurance) money. Society develops a problem like using the internet too much. Suddenly there is a diagnosis for internet addiction.

Second, it is too easy to put people into a diagnostic box and imagine that we understand them. Dangerously, we may think we can predict their course of illness. In response to the psychological power of your expertise, your patient may essentially become their diagnosis. For many, it is a way of simplifying a complex world but at the cost of setting limits on that person's growth and progress. "I have an anxiety disorder and will all of my life" versus "I had not yet learned to manage anxiety, but my therapist has taught me skills to do so. I'm no longer a highly anxious person."

Third, carrying a psychiatric diagnosis can stigmatize your patients. Eighty years of saying "mental illness is an illness just like any other illness" has had very little impact on how the vast majority of people think. That may not be right, but it is true.

Want evidence? The stigma is such that most people won't pay the price of carrying a diagnosis in order to get your help. The Rand Corporation (Manning et. al, 1984) looked at the impact of the size of the co-pay on utilization. The co-pay ranged from 50% to 0%. Just as you would predict, as the co-pay went down, utilization went up. But--and here is the kicker--when therapy was free, when the co-pay was zero, only 10% of people would come to therapy. To be fair, this is an old study. Candidly, I have not kept up with that literature. Maybe there has been some change in the stigma of going to therapy. Maybe the stigma has lessened such that only 70% or 80% avoid therapy because of it. You may have the impression that everybody is going to therapy because your waiting list has never been longer. I strongly suspect that this is an artifact of COVID having done a number on society. Will it last? Who knows? But even if the stigma only affects 50% of the population now, that means that a lot of people are still left out of a process that could have life changing value for them.

Everybody needs you. Here is how I know: I worked first as a clinical psychologist for about twenty-five years, including the time in which I had an insurance free practice. Then I evolved into working as an executive coach which I've done for another twenty-five years. Because of these broad experiences, I've been able to work with people on the full spectrum of human capacity, from very limited people to highly successful ones. I can assure you that 100% of us have significant problems. No one is dealt all the cards, not even those people whom you may secretly envy. I don't think that we are in any position to say that Joe is sick, but Susie isn't. It isn't that we, as psychologists, are necessarily better adjusted than the person sitting in the consulting room with us. Our expertise comes from having studied how to solve human problems. Hopefully, we pass those skills onto those who consult us. But perhaps you have noticed in your own life that once you solved problem A, problem B comes long to challenge you.

In summary, if you want to get out of the insurance morass, for the benefit of your patients as well as yourself, you have to step away from the psychiatric system. I propose that you change your identity from healthcare provider to agent of human change. To be clear, that doesn't mean that you might not work within healthcare helping patients beat cancer, learn to live with heart disease, etc. But whatever context you chose to work within, consider thinking of yourself as someone whose expertise is helping people make the changes in their lives that will make their lives better. Note that I'm saying that if this proposed change only benefitted psychologists, it should not be done. Again, both you and the people you work with will benefit.

Changing the way that you think about your professional identity can open up opportunities that otherwise don't exist, again, not just for you but for those who come to see you. As an example, several decades ago, the railroad industry hit bad times. Many famously successful railroads went out of business. But those who redefined themselves as being, not in the railroad business but rather the transportation business, thrived. Because they thrived, they could give their customers services that were needed.

To illustrate, here is how my translation went. First, I transformed my clinical practice into one free of insurance. In that process, and in the process of writing ***Breaking Free***, I got very interested in working with leaders, helping them learn psychological skills to be more effective, to be able to elicit higher performance from the people they lead. I've had the pleasure of watching highly successful people become much more successful and they, in turn, help the people who report to them be more successful. Further, my clients often tell me that they take what they have learned home with them. Their spouses are often my biggest fans, even though we may never meet.

Identity change is hard. You know that because you help people do it all the time. I was there when we won the "right" to third party reimbursement. We then thought we were "real doctors." We weren't. We were/are something different, every bit as valuable and often more so. Again, consider what you do for people. You help them lift their mood so that they can more fully participate in life. You help the conquer anxiety that has limited what they can do and contribute. You help them find strengths within themselves that they hadn't recognized. You help them make families that work.

You might say: "But I like relieving human suffering. I like helping people with very serious problems." Please, keep doing that. It just doesn't require that you label yourself as a healthcare provider even though you will be impacting people's real health issues quite positively.

With regard to a different way of thinking, consider the Problem Solving/Skill Building model as an alternative to psychiatric diagnoses. People come to you with problems, and you help them build the skills that they need to solve or manage those problems. Within Problem Solving/Skill Building, you can use multiple models that fit your way of doing therapy and the client's needs, such as Cognitive-Behavioral, Psychodynamic, Solution Focused, and countless others. I also encourage you to take a look at models of emotional intelligence (EQ) as an additional approach. EQ has been used widely in executive coaching and has great utility for therapy. You will see that the skills that comprise EQ are many of the same skills you already help people learn. Here is a link to my coaching website that lists the sixteen EQ skills: https://eqleader.net/PDFs/16LearnableSkills.pdf

Now What: Suppose you are now saying: "OK. I'm beyond motivated. I can see some of the changes in thinking I need to make. I need to be as courageous as my patients. But what do I actually do?"

Breaking Free of Managed Care (again, I no longer receive royalties) can walk you through steps that work. Since I can't write a whole book for the ***Independent Practitioner***, here is a short list of things that you will want to do.

- As mentioned, figure out your new fee schedule and new policies. You may be surprised about how many of you policies were insurance driven, not patient driven. But don't just spring the changes on people. When I began my transition to a clinical practice outside insurance, I introduced new clients (that's what I decided to call them) to my new approach to payment. I gave all current patients six months' notice of the changes. That gave them time to either finish up their work with me or decide whether they wanted to switch therapists. As I recall, no one opted

to switch to a different therapist.

- You need to educate clients/patients about why you are stepping out of the insurance process. Hint: They won't and shouldn't care about how it is better for you. They only should care about how it is better for them. You can talk about greater privacy, i.e., none of their highly personal information goes into big computer systems. Talk about greater control because only the two of you decide what you discuss in the sessions and how long you work together. Talk about the potential danger of having to have a psychiatric diagnosis. Finally, help them see the economic advantages of paying out of pocket.
- You may find that your relationships with patients become even deeper, more impactful, as you set all of the insurance driven aspects aside. You may find that it is easier to step out of the constraints of "all knowing expert" to a relationship that can be described as: "I'm an expert in psychology and human change. You are an expert in you and your situation. Let's combine our expertise to make good things happen." When people are not in a one-down position, it is amazing how much more they can grow.
- You will need to educate your referral sources about the changes that you are making and why. Just as you educate your new patients or clients about the benefits of this change to them, share those benefits with your referral sources. Remember, when someone makes a referral to you, they don't really care about you. They care about the person whom they are referring and what will be good for them. You may worry how your referral sources react to the changes you make. My referrals went up. My referral sources saw my change as an ethical and courageous statement.
- You will need to change your website and other approaches to marketing. In ***Breaking Free***, you will find the Six Steps of Marketing as a guide. It served me and others very well in building/maintaining a thriving practice. In the meantime, remove psychiatric language from marketing materials such as your website. Trust me. That language is off putting. Part of our responsibility is to be able to explain things to people in lay language. In other words, we need to learn to speak their language, not force them to learn ours.

Here are some examples:

- *Instead of "I treat depression" you could say "I help sad people find hope."*
- *Instead of "I treat anxiety disorders" you could say "I help people find courage."*
- *"I help children learn how to make friends."*
- *"I help families love again."*

Given that there are lots of therapists, it will help to have a professional identity in your community beyond just being a therapist--something that makes referral sources think of you as opposed to some other therapist. As an analogy, let's say that you are going to "the store." Which store? That depends on what you are looking for. If you need a hammer, you are not likely to go the grocery store. You are going to go to the hardware store because they have positioned themselves to be known for having hammers.

Learning how to create such an identity was a focus of our Breaking Free workshop exercises. We devised ways therapist could identify specialties that fit them. Here's one of the exercises we did. We distributed magazine ads for participants to study, including ads for cigarettes, alcohol, cars, clothes, etc. We asked: "What is this ad really selling?" While not in so many words, it became clear that these ads were selling things like status, belonging, sex, connecting, and so forth. Wait a minute! Isn't that what you do? Don't you help people learn to connect? Don't you help them find a place in the world (status)? Don't you help them figure out how to have sexual relationships that have actual meaning? The skills you help people learn are far better help in creating sustainable connections than a shot of vodka.

Companies pay big bucks to marketing companies to see what motivates buyers. Looking at ads in popular media (for free!) can give you ideas beyond what there is space to discuss in this article. Further, you already know a lot about what motivates people. Your job is to figure out how you might communicate your ability to help people achieve goals in appealing language that people can understand.

We also did another exercise that you may find useful:

- Identify a patient who is/has been particularly meaningful for you to work with. What were the issues that mattered to them? Perhaps those issues could be a specialty for you.
- Repeat this exercise with several of your clients/patients. What themes emerge? These are your professional passions.

Here are some examples of what some of our workshop participants discovered:

- *One woman had immigrated to the US ten years prior. She was well aware of the stressors that immigrants face. She decided that helping new immigrants adapt to the US would be a specialty area for her.*
- *Another person was particularly interested in attachment issues that often develop for foster children, which often extend into adulthood. That became her specialty.*
- *A third therapist decided to specialize in "Getting out of debt."*

In closing, I hope that you find this article useful as a beginning guide to extricate yourself from the abusive relationship that you currently have with health insurance. Making this transition will help you and everyone who comes to see you. As stated earlier, if this change only benefitted us, it should not be done. We are in fiduciary relationships with those who seek our services. That means that their welfare comes before ours. But that doesn't mean that we ignore our own welfare. The best relationships work both ways.

You will experience a good bit of anxiety at times. You will be tempted to retreat at times. I certainly was. You will likely have many colleagues who are naysayers as it may make them anxious to see you get free of abuse. You doing so will challenge the assumptions that they have been making that allow them to continue to stay stuck, so they will try to talk you out of it. Don't let their anxiety become yours. The courage that you develop in this process will inspire people who come to you to find their own courage.

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Dr. Friendstatic Interview

by Eileen Kennedy-Moore

Working with children in mental health treatment can be a rewarding part of any professional journey, one that brings joys and challenges. There is magic in connecting with kids and Eileen Kennedy-Moore has lived in this space for years. It's clear from this interview that she revels in the psychology of the young mind and children's uncanny ability to know what they need psychologically. They may not know how to articulate it or how to get it, but they know what they need.

In this article, she answers our questions about her work and the passion behind her work.

What appeals to you about working with children in treatment?

I work with adults, children, and families. I enjoy the variety, and I appreciate the more nuanced work with my adult clients but also like the fun of engaging kids. I'm a mom of four grown children, so I feel comfortable around kids.

Sometimes the variety of work feels like I'm in that circus act, running from pole to pole to keep the plates spinning, but mostly my different roles draw from and enrich each other.

Kids are very astute at telling whether adults genuinely like and care about them. The most gratifying part of working with kids is that a little bit of intervention early on can make a lasting difference that enables them to feel more capable, confident, and connected; prevents suffering; and shifts their lives in a healthier direction.

What's the hardest part of this work?

The hardest part is when kids are in bad situations that they have no power to change. In those situations, we can acknowledge their feelings and perceptions, which is something, but it doesn't feel like enough.

You have a podcast called "Kids Ask Dr. Friendtastic" where you offer friendship advice for children. Share with us how you got started with this idea and some of the exciting things that have happened during your conversations with children.

Growing up, my family moved every three to five years, so you could say I became an expert on making friends at a young age. Close friends make the good times more fun and the hard times easier to bear.

As an adult, I hear about kids' friendship concerns every day in my practice. I've also read a lot of research about children's friendships, and the research shows a strong connection between friendship and coping. Simply put, if we want kids to feel happier, navigate stress in a healthier way, feel more engaged at school, and be less likely to get bullied or be a bully, strong friendships can help!

I started the "Kids Ask Dr. Friendtastic" podcast in January 2023, and it's been a labor of love. I wanted to honor and attend to children's questions about friendship in a meaningful way. Each weekly, five-minute episode features an audio recording of a question about friendship from a kid plus a practical and thought-provoking answer. There's also a transcript for accessibility plus discussion questions parents (or teachers) can use to further their children's understanding. The podcast is available for free on all podcast platforms or on my website for kids: Kids Ask Dr. Friendtastic - Podcast

What have you noticed about the questions from children?

The kids' voices are adorable, and their questions are deep! Although the circumstances are child-centered, the issues they raise touch on universal concerns such as longing for intimacy, negotiating separateness, choosing when and how to speak up, coping with feelings such as hurt or jealousy, repairing a relationship after a conflict, and deciding when to accept, forgive, or move on.

Tell us about the feedback that you have received over the last year.

I've received many emails from parents talking about how their kids look forward to new podcast episodes each week and listen to them over and over. I also often hear, "This applies to adults!" Absolutely! It's not like we learn all there is to know about friendship at 9-years-old, and then we're done. In new situations and new relationships, we're all constantly learning.

What's one piece of advice that you would share with parents?

One of our most important jobs as parents is to help kids learn how to be in relationships. We can teach kids explicitly about how to connect, communicate, and get along, but they learn more from what we do than from what we say. We need to think about what we're teaching our kids as they watch our interactions with them, other family members, friends, neighbors, and community members.

What's one piece of wisdom you can share with a budding child psychologist?

Be respectful of parents' knowledge–no one has logged more hours or years with their kid!

Parent bashing is common on social media, but the vast majority of parents love their kids and want to do right by them. I often say to parents in my practice, "I'm an expert on psychology, in general, but you are the expert on your child and your family. We're going to put our heads together to figure out how to move forward."

What are your other projects related to friendships and relationships?

In addition to my practice and podcast, I have a blog, "Growing Friendships," on *Psychology-Today.com* with over five million views, a "Dr. Friendtastic for Parents" newsletter on Substack, and an audio-video series for *The Great Courses/Wondrium*.

I've also written nine books for parents, kids, or mental health professionals. Recent books are:

Moody Moody Cars (for ages 4-8)

Growing Feelings: A Kids' Guide to Dealing with Emotions about Friends and Other Kids (for ages 6-12)

Kid Confidence: Help Your Child Make Friends, Build Resilience, and Develop Real Self-Esteem (for parents)

Even the topics and areas of psychology that we love can burn us out. Tell us about your drive to continue this work.

I'm deeply committed to giving psychology away. Right now, that work feels especially urgent. The epidemic of loneliness among adults, the mental health crisis among teens, and the painful divisiveness in our society and our world could all be helped if we teach kids how to build strong and caring friendships.

Lastly, tell us where to find you and how to support the important work you are doing in our field.

Learn more at Eileen Kennedy-Moore, PhD or Kids Ask Dr. Friendtastic - Podcast. If you know a kid (age 5-13) who has a question about friendship, I'd love to answer it! Please help them submit it to Submit a Podcast Request -

What You May Not Know About Accepting Credit Cards

Pauline Wallin

Accepting credit cards is convenient for both you and your clients. Furthermore, with clients' accounts kept up to date with credit card payments, the issue of unpaid bills does not become the elephant in the room during your work together.

No doubt, you know (or can easily learn) how to process credit card payments. But, like many mental health professionals, you may be misinformed about privacy and other issues in the context of accepting credit cards.

NOTE: The following is for informational purposes only, and is not intended as legal or financial advice.

1. HIPAA compliance is often misunderstood when it comes to credit card processing.

Colleagues often ask about "HIPAA-compliant" credit card processing, without understanding what that means.

HIPAA rules do permit limited disclosure of protected health information (PHI) such as name and address for payment processing. See the highlighted section in the excerpt below (from https://www.govinfo.gov/content/pkg/CFR-2013-title45-vol1/pdf/CFR-2013-title45-vol1-sec164-502.pdf).

> § 164.502 Uses and disclosures of protected health information: General rules.
> (a) Standard. A covered entity or business associate may not use or disclose protected health information, except as permitted or required by this subpart or by subpart C of part 160 of this subchapter.
>
> (1) Covered entities: Permitted uses and disclosures. A covered entity is permitted to use or disclose protected health information as follows:
>
> (i) To the individual;
>
> (ii) For treatment, payment, or health care operations, as permitted by and in compliance with § 164.506

Limit PHI to the minimum necessary - for example, name and zip code. If your credit card processor requires a description of what the charge is for, write something generic such as "Professional service." **Never include procedure code or diagnosis**.

2. A business associate agreement (BAA) is not required between you and the credit card payment processor.

HIPAA does not require you to have a BAA with a bank for processing clients' checks, even though the checks typically show clients' names and addresses, as well as the fact that their checks are made out to you, a mental health professional. The same goes for credit card processors.

The reason for this is described in the highlighted section below. The text is copied from the US Health & Human Services website, under the heading, "Other situations in which a business associate contract is not required:"

> When a financial institution processes consumer-conducted financial transactions by debit, credit, or other payment card, clears checks, initiates or processes electronic funds transfers, or conducts any other activity that directly facilitates or effects the transfer of funds for payment for health care or health plan premiums. When it conducts these activities, the financial institution is providing its normal banking or other financial transaction services to its customers; it is not performing a function or activity for, or on behalf of, the covered entity.
> https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/business-associates/index.html

In other words, the financial institution is not conducting business on your behalf, but on the cardholder's behalf. Thus, in my opinion, there is no need for a BAA between you and the credit card processor.

3. If you have patients' written permission to keep their credit card info on file, you may not be storing it correctly.

Some psychologists store people's credit card numbers on a piece of paper in a locked file cabinet, or in a password-protected electronic document - as they would with other types of patient records, in compliance with HIPAA. However, HIPAA does not apply to the storage of credit card information.

The relevant compliance rule is PCI DSS (Payment Card Industry Digital Security Standard) which is complex and expensive to implement.

Most companies like Square, Ivy Pay, and practice management software are PCI DSS compliant, and can store credit card info for you legally and securely. Many also include credit-card-on-file authorization forms that you can have clients sign.

4. In some US states, it is illegal to pass the credit card merchant fee on to the customer.

When you accept a payment via credit card, you are charged a merchant fee of about 3% to 4% by the payment processing company. Most businesses absorb this fee as part of their overhead.

Nevertheless, some psychologists do pass the merchant fee on to their clients as a surcharge. For example, if the client owes $100 and the merchant fee is 3%, they are charged $100 + $3, so that the psychologist ends up with the full $100 rather than $97 after the processor takes their 3%.
Surcharges are not allowed on debit card and gift card transactions. However, they are legal (at the time of this writing) for credit card transactions in all states except these: Connecticut, Maine, Massachusetts, and Oklahoma, as well as Puerto Rico.

In addition, some states that do allow surcharges on credit cards require that it be disclosed up front, and that it be listed in a separate line on the customer's receipt.

For the latest regulations and other information about surcharges, check with your state government and with your credit card processor.

5. Efforts to maintain confidentiality on patients' credit card statements may sometimes backfire.

When you sign up for a credit card merchant account, you can designate the name that you want displayed on clients' transaction statements.

Being mindful that clients' spouses may have access to their credit card activity, and that clients may not have told their spouse that they've been seeing you, some psychologists choose a merchant account name that differs from their practice name.

For example, let's say your practice name is "Spring Meadow Mental Health Associates," but for your merchant account name (which appears on clients' statements) you use the initials SMMHA.

Furthermore, let's assume that when the client reviews their credit card bill and see charges for "SMMHA," they have no idea what it is for. Figuring that it's an error, the client disputes the charges with their credit card issuer.

If this happens, the credit card company informs you of the dispute and conducts an investigation. Chances are that you will eventually prevail, but in the meantime the dollar amount in dispute may be temporarily removed from

your checking account as a "chargeback." If you do choose to use a different business name for credit card transactions, you can minimize the hassle of chargebacks by informing the client, each time you run their credit card, what they can expect to see on their statement. It's also a good idea to include this information on the receipt that you give them, and on the informed consent document they sign at the beginning of treatment.

Even then, a client may not pay attention, or forget by the time they review their credit card statement. If they do dispute the charge, you would have plenty of documentation that they were informed and agreed to it.

Pauline Wallin, PhD is in private practice in Camp Hill, PA. She is also cofounder of The Practice Institute, LLC, which provides business consultation to mental health professionals.

Sport Psychology: What Is It and What Does a Sport Psychologist Do?

Michael D. Zito

Clinical, Sport, and Performance Psychology

What is a Sport Psychologist?

In the United States, a Sport Psychologist must be a licensed Psychologist. This means that the professional has a doctoral degree in Psychology and has passed the licensing requirements in the state in which they practice. Most states require a licensed Psychologist to have two years of supervised practice and to pass a licensing exam. In addition to the licensed Psychologist requirements, ethically, a Sport Psychologist also must have advanced training in Sport and Performance Psychology. This can be in the form of coursework, but ideally also should include supervised work to demonstrate competence in the Sport and Performance settings which may meet the American Psychological DIV 47 proficiency standard, depending on your specific circumstance. This proficiency standard indicates that a Sport Psychologist should have training in psychological skills (e.g., stress and anxiety management and emotional regulation) that promote athlete mental health within a sport environment. Further, the proficiency states the following are needed (see link below for more details):

- Knowledge of theory and research in social, historical, cultural, and developmental foundations of Sport Psychology
- Principles and practices of Applied Sport Psychology, including issues and techniques of sport-specific psychological assessment and mental skills training for performance enhancement and satisfaction within the sport environment
- Clinical and counseling issues with athletes
- Organizational and systemic aspects of sport teams and athlete needs within a particular sport culture
- Understanding of the developmental and social issues related to sport participation
- Knowledge of the biobehavioral bases of sport and exercise (e.g., exercise physiology, motor learning, sports medicine)

A Psychologist who also is an athlete and/or coach would not meet the proficiency standard and should not use the professional title of Sport Psychologist. Sport and Performance Psychology requires a significant amount of training. While the proficiency standard does not directly mention supervision, it is strongly advised to do so.

Another avenue for obtaining Sport and Performance Psychology proficiency is through a certification from a bona fide organization. For example, the Association for Applied Sport Psychology (AASP) offers a certification that can meet some of the APA proficiency standards. To be a Certified Mental Performance Consultant (CMPC), the professional must satisfy course work requirements which do overlap with some of the APA Proficiency, pass an exam, and have 400 hours of supervised work. The CMPC by itself does not qualify an individual to be a Sport Psychologist but, combined with the Psychology licensure requirements, may give practitioners the ability to ethically do so. For those not licensed as a Psychologist but who have training or degrees in Sport Psychology, these individuals cannot refer to themselves as Sport Psychologists or Sport Psychology consultants since these terms are protected by law for use only by licensed Psychologists, in most states. Non-licensed practitioners with Sport Psychology degrees or advanced training could legally refer to themselves as "CMPCs," "Performance Consultants," or "Mental Skills Trainers" (AASP, n.d.).

What does a Sport Psychologist do?

Sport Psychologists are uniquely trained in assessment, diagnosis, and treatment of a broad range of mental health issues that can inhibit maximum human performance. In addition, they can assess performance-related factors and apply psychological, cognitive, behavioral, emotional and/or psychophysiological techniques that facilitate maximal performance in both athletic and performance domains. Sport Psychologists can work directly with athletes, groups, teams, coaches and/or sport organizations. This may include youth, high school, intercollegiate, elite, Olympic, professional, and recreational levels. The types of services Sport Psychologists could provide are assessment, psychological skills training, performance enhancement techniques (i.e., goal setting, emotional regulation, confidence, visualization, high performance mindset), injury recovery, psychophysiological interventions (e.g., biofeedback, heart rate variability monitoring), career transitions, team building, character development, parent training, and/or coach education.

Sport Psychologists' interventions also are appropriate for performance domains (i.e., actors, musicians, chess players, business personnel, military, and special operation forces). Actors, musicians, and chess players often struggle with performance anxiety. Business personnel and organizations, military and special operation forces could all benefit from developing high performance mindsets. Some Sport Psychologists provide business consultation to develop high performance cultures.

For additional information, please see links below for relevant resources.

Relevant Links:

American Psychological Association-Division 47 (n.d.-a). *APA sport psychology proficiency.* https://www.apadivisions.org/division-47/about/sport-proficiency

American Psychological Association-Division 47 (n.d.-b). *What Is Exercise Psychology and Sport Psychology?* What Is Exercise Psychology and Sport Psychology? (apadivisions.org)

American Psychological Association-Division 47 (n.d.-c) Society for Sport, Exercise & Performance Psychology. About the Division of Exercise and Sport Psychology (apadivisions.org)

Association for Applied Sport Psychology (AASP) (n.d.) *Certified Mental Performance Consultant (CMPC).* Certification | Association for Applied Sport Psychology

Michael D. Zito, Ph.D., CMPC is a Licensed Psychologist in NJ and NY who has practiced Clinical, Sport and Performance Psychology for 30 years with children, adolescents, adults, couples and families. His sport and performance clients have included professional, Olympic, collegiate, high school and youth athletes, and Broadway actors and competitive chess players. He taught University courses in Clinical and Sport Psychology for 14 years, authored 7 book chapters and is presently a consulting Sport Psychologist and clinical supervisor for Rutgers University.

Free Continuing Education (CE) Credits for Psychologists

(2.5 APA- and CPA-approved credits)! This project, funded by the National Science Foundation, is being performed to better understand how mental health professionals come to conclusions and make decisions in evaluations in legally-relevant cases. It also includes personalized feedback to help you understand your own behaviors with a didactic portion with video instruction. First is a dynamic and interactive portion in which you read materials from a case and make judgments about the material, followed by tailored feedback about your performance and suggestions for how to improve your expert judgment. Then, a didactic portion with video content follows. Please click here for more information and to participate: https://training.concept.paloaltou.edu/courses/neal-pronin-research.

Continuing Education

Continuing Education Webinars 2023

Check out these offerings from our CE Committee for 2023!

Introduction to Acceptance and Commitment Therapy (ACT):

September 12, 2023 (2pm-4pm EST) – Learn more and **REGISTER HERE**: http://division42.ce21.com/item/introduction-acceptance-commitment-therapy-act-122881

Whither Masculinity: "Man up" or "Human Up":

September 22, 2023 (12pm-1:30pm EST) – Learn more and **REGISTER HERE**: http://division42.ce21.com/item/whither-masculinity-man-human-up-122884

Beginning or Adding a Forensics Component to Independent Clinical Practice:

October 19, 2023 (12:00pm-1:30pm EST) – Learn More and Register Here: https://division42.ce21.com/item/beginning-adding-forensic-component-independent-clinical-practice-123031

Basic of Criminal Law for Psychologists:

November 9, 2023 (12pm-1:30pm EST) - Learn More and Register Here: https://division42.ce21.com/item/basics-criminal-law-psychologists-123042

Basics of Civil Personal Injury Law for Psychologists:

December 7, 2023 (12:00pm-1:30pm EST) – Learn More and Register Here: https://division42.ce21.com/item/basics-civil-personal-injury-law-psychologists-123051

Nuts and Bolts of Testifying as an Expert Witness:

January 11, 2024 (12:00pm-1:30pm EST) – Learn More and Register Here: http://division42.ce21.com/item/nuts-bolts-testifying-expert-witness-123054

Please let me know if you have any questions: Cami Winkelspecht, Ph.D (CE committee chair and member-at-large) (dr.cami@childpsychologysolutions.com).

Free new resource for psychologists: Special issue

New! Free resource for attorneys, judges, psychologists. FREE special issue on Psychological Assessment in Legal Contexts in the Journal of Personality Assessment.

Comprehensive, credible reviews and critiques of psychometric evidence & legal status of commonly-used psychological & personality assessment measures used in forensic evaluations. 11 papers & a summary intro & editorial analysis. Entire free issue here: https://www.tandfonline.com/toc/hjpa20/104/2

These articles offer clarity about strengths & weaknesses of a number of instruments to inform psychologists' preparation for expert testimony, lawyers' preparation for direct and cross-examination, judges' evidence admissibility determinations, and scholars' future research.

Articles on the Rorschach/R-PAS, MMPI-3, PCL-R, MCMI-IV & MACI-II, PAI and PAI-A, SIRS-2, HCR-20V3, TSI & TSI-2, & MacCAT-CA, ECST-R, and CAST*MR are included. To increase visibility, accessibility, & impact, published as free access, meaning available to download without charge.

We hope these articles will be widely read and useful to scholars and practitioners in both psychology and law. Please share to spread the word with your network in the hopes that people who can make use of this great resource become aware that it exists!

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